

NOTICE OF FORM CHANGE NO. 05-010

DATE

01/11/2005

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

Community Care Licensing District Offices
 Private and Public Adoption Agencies

District Attorney
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE FC 18 (11/04) - Notification Of AFDC-Foster Care Transfer

ORDER UNIT MASTER ONLY	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM 11/04	REPLACES 1/00	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788		<input type="checkbox"/> Other:	

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY

Use until exhausted Destroy

USE NEW FORM

When supply available in DSS Warehouse Use new form effective 11/04

USE FORM IN ACCORDANCE WITH

All County Letter No.
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Form is a Master Only.

Attached is a Reproducible Copy

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

DATE:

NOTIFICATION OF AFDC-FOSTER CARE TRANSFER

SECTION A - SENDING COUNTY COMPLETES (PLEASE TYPE OR PRINT)

CASE NAME	CASE NUMBER	CHILD'S PARENTS' NAME(S)
CHILD'S NAME	CHILD'S SOCIAL SECURITY NUMBER	DA CHILD SUPPORT NUMBER(S)
SENDING COUNTY ADDRESS	PAYEE NAME (IF FAMILY PLACEMENT - RELATIONSHIP)	
RECEIVING COUNTY ADDRESS	ADDRESS OF FOSTER HOME OR INSTITUTION	
DISCONTINUANCE DATE/END OF TRANSFER PERIOD	DATE JURISDICTION TRANSFERRED	TELEPHONE NUMBER: ()

CURRENT PAYMENT AMOUNT:	BASIC RATE: \$	SPECIALIZED CARE RATE: \$	INFANT SUPPLEMENT: \$	CURRENT CLOTHING ALLOWANCE: \$	<input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL:	
AID PROGRAMS:	<input type="checkbox"/> FEDERAL FOSTER CARE <input type="checkbox"/> MEDI-CAL ONLY	<input type="checkbox"/> STATE FOSTER CARE <input type="checkbox"/> COUNTY ONLY	<input type="checkbox"/> EMERGENCY ASSISTANCE	"NOT-TO-EXCEED DATE:" _____		

DOCUMENTATION:

ENCLOSED N/A

- EA AUTHORIZATION DOCUMENTS [EA 1/ ACE SCREEN PRINT, OR OTHER DOCUMENTS]
- SAWS 1
- FC 2/JA 2
- SOC 158A OR EQUIVALENT: _____
- BIRTH CERTIFICATE/ALIEN STATUS DOCUMENTATION
- SOCIAL SECURITY NUMBER DOCUMENTATION
- FC 3/FC 3A - VERIFICATION OF DEPRIVATION
- EVIDENCE SUPPORTING FEDERAL ELIGIBILITY [LINKAGE & DEPRIVATION]
- COURT ORDER/AUTHORITY FOR PLACEMENT DOCUMENTATION
 - DETENTION ORDER
 - TRANSFER OF JURISDICTION
 - JURISDICTION ORDER
 - PERMANENCY HEARING ORDER(S) WITH REASONABLE EFFORTS FINDINGS
- DOCUMENTATION OF THREE JUDICIAL FINDINGS
- GUARDIANSHIP/RELINQUISHMENT PAPERS
- DISPOSITION ORDER
- PROPERTY OF MINOR/TRUST INFORMATION
- INCOME OF MINOR: _____ TYPE: _____ AMOUNT \$ _____
- INDEPENDENT LIVING PLAN
- 18 YEARS OLD AND OVER DOCUMENTS [MUTUAL AGREEMENT, SCHOOL VERIFICATION]
- DHS6155 HEALTH INSURANCE QUESTIONNAIRE
- APPLICATIONS PENDING (SSI/SSP)
- FC 4
- OTHER: _____

SOCIAL WORKER'S NAME	SOCIAL WORKER NUMBER	SOCIAL WORKER'S TELEPHONE NUMBER ()
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COMMENTS:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ()
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SECTION B: RECEIVING COUNTY COMPLETES: (PLEASE TYPE OR PRINT)

<input type="checkbox"/> TRANSFER ACCEPTED	<input type="checkbox"/> TRANSFER NOT ACCEPTED - REASON:
<input type="checkbox"/> CASE ELIGIBLE - WILL BEGIN ON:	<input type="checkbox"/> CASE INELIGIBLE - REASON:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ()
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DISTRICT OFFICE